ZULHASNIMAR HASSAN BASRI & ANOR v. DR KUPPU VELUMANI P & ORS

COURT OF APPEAL, PUTRAJAYA
ALIZATUL KHAIR OSMAN JCA
ABDUL AZIZ ABDUL RAHIM JCA
VARGHESE GEORGE JCA
[CIVIL APPEAL NO: W-02-2222-2011]
18 MARCH 2016

TORT: *Negligence – Medical negligence – Breach – Allegation of – Infant born with severe prenatal asphyxia and transient multi organ failure – Whether there was breach of duty on defendants' part in handling pregnant patient when she collapsed due to severe bleeding – Whether there was delay in caesarean section that caused infant to be born with birth defects – Whether patient was in labour at time of admission to hospital – Whether probable cause of collapse in patient due to uterine rupture or placenta percreta – Whether there was sufficient judicial appreciation of evidence by trial judge*

TORT: *Negligence – Medical negligence – Liability – Infant born with severe prenatal asphyxia and transient multi organ failure – Whether there was breach of duty on defendants' part in handling pregnant patient – Whether trial judge analysed evidence of facts on every action taken by nurses and doctors in hospital – Whether hospital vicariously liable*

The first defendant and the second defendant practised at Ampang Puteri Specialist Hospital ('the third defendant') as a consultant obstetrician and gynaecologist. The first plaintiff, a patient of the first defendant, had arrived at the third defendant hospital in the early hours of 3 May 2002 with abdominal pain. She was in her 36th week of pregnancy. The first defendant noted the results of the CTG undertaken on the first plaintiff and found that the foetal heart was good while the contractions were 'irregular and mild'. At 10am, the first defendant concluded that the first plaintiff was not in labour. However, at 10.55am, the first plaintiff collapsed as a result of severe bleeding. The first plaintiff was resuscitated in the ward and sent to the operation theatre ('OT'). The first defendant, assisted by the second defendant, performed a lower segment caesarean section (LSCS) on the first plaintiff at 11.20am. A hysterectomy was conducted and a placenta percreta was discovered. At around 11.25am, the second plaintiff was born prematurely with severe prenatal asphyxia and with transient multi-organ failure, causing her to suffer from severe birth asphyxia leading to hypoxic ischemic encephalopathy (HIE). The plaintiffs thus sued the defendants for medical negligence. The High Court Judge, in dismissing the plaintiffs' claim against the defendants, concluded that there was no breach of duty or negligence on the first and second defendants' part in the handling of the first plaintiff after she collapsed. The trial judge proceeded to hold that the delivery of the second plaintiff within 30 minutes from the time of the first

plaintiff's collapse was in fact within internationally acceptable standard. The trial judge also found that the third defendant was not vicariously liable since there was no negligence on the part of the first and second defendants. Hence, this appeal. The issues that arose herein were, *inter alia* (i) whether the trial judge misdirected herself on the issue of vicarious liability on the part of the third defendant; (ii) whether there was delay on the part of the first defendant in attending to and managing the first plaintiff; (iii) whether the first plaintiff was in labour upon admission; (iv) whether the probable cause of the collapse in the first plaintiff was due to uterine rupture or rupture of the vessels on the uterus resulting from a condition called placenta percreta; and (v) whether there was insufficient judicial appreciation of the evidence by the trial judge.

Held (dismissing appeal)
Per Abdul Aziz Abdul Rahim JCA delivering the judgment of the court:

(1) In arriving at the decision that the first and second defendants were not liable and that the hospital was also not vicariously liable, the trial judge had painstakingly analysed the evidence of facts as to every action taken by the nurses and the doctors including the first and second defendants, as specialists in attending to the plaintiffs. These evidence and acts of the nurses and doctors employed by the hospital to attend to the plaintiffs had been detailed in the third defendant's written submissions. The trial judge had correctly concluded that the third defendant was not negligent though she did not specifically address the claim against the third defendant, the hospital, based on direct liability. (para 21)

(2) The evidence and the facts in this case did not support the plaintiffs' contention that the first and second defendants were negligent. When the first plaintiff arrived at the hospital on that fateful day, she was not in labour and the foetus was well. This fact was established by the various checks performed on her. The trial judge had meticulously considered and examined the evidence relied on by the plaintiffs to support the contention that the first plaintiff could have collapsed at 10.45am or even earlier at 10.40am as suggested by the plaintiff, and had come to a finding of fact that the collapse occurred at about 11am. Therefore, if the second plaintiff was delivered at 11.25am it was within the acceptable 30 minute window. Thus, on the evidence and the finding of fact by the trial judge, it could not be said that there was delay by the defendants in attending to the first plaintiff. (paras 21 & 42)

(3) The first plaintiff had come to the hospital at 6.30am with lower abdominal pain and upon report by the staff nurse in attendance, she concluded that the first plaintiff was not in labour and prescribed her with Pethidine and Phenergan to suppress the pain of abdominal muscles. The first defendant maintained in her evidence that before the first plaintiff's collapse in the ward, there was no indication that

warranted a Caesarean Section to be performed on the first plaintiff. The trial judge had reviewed the medical literature referred to or cited to her on the issue of labour at near term or on full term pregnancy. Having done so, she concluded that the first plaintiff was not in labour at the time of admission or at any time after that up to the time when the first plaintiff collapsed in the ward. (paras 44 & 46)

(4) In analysing the evidence adduced by the plaintiffs to show a rupture of the uterus, the trial judge had considered the evidence and opinion of the first and second defendants as well as evidence of the experts called by both sides. The evidence showed that there was no uterine rupture. When the first plaintiff was taken to the OT after the collapse, the first and second defendant testified that the uterus was intact with the placenta. It was discovered that it was the vessels on the outer surface of the uterus, at the fundus, that ruptured (placenta percreta). Her Ladyship observed that the evidence of the first defendant, the second defendant and the expert Dr Raman, the pathologist Dr Patel, as well as the plaintiffs' own expert Dr Ong was consistent that placenta percreta was a rare condition and could not be detected even with advance imaging techniques. The second defendant in his evidence said that placenta percreta at the fundus as in this case was even rarer because it did not give out any symptoms. This view was shared by Dr Ong the plaintiffs' own expert. The rarity of placenta percreta condition was confirmed by Dr Patel when he testified that in his 20 years of practice as a pathologist he had only seen one of such a case which was the present case.There was no reason to differ from the conclusion reached by the trial judge on the issue that the bleeding was caused by the bursting of the vein. (paras 31-36)

(5) The opinions of the experts are a question of fact. There was nothing wrong in the trial judge's preference of one expert opinion over the other if she could reasonably explain the preference, which was done in the instant case. This court could not find fault with the manner the trial judge had judicially considered all the evidence in this case in arriving at her finding of facts. The plaintiffs had failed to establish, on a balance of probabilities, a case in negligence against the defendants. (paras 47-53)

Bahasa Malaysia *Headnotes*

Defendan pertama dan defendan kedua berkhidmat di Hospital Pakar Ampang Puteri ('defendan ketiga') sebagai pakar perunding obstetrik dan ginekologi. Plaintif pertama, pesakit defendan pertama, tiba di hospital defendan ketiga pada pagi 3 Mei 2002 dalam keadaan sakit di bahagian abdomen. Plaintif pertama pada masa itu mengandung 36 minggu. Defendan pertama selepas memerhatikan keputusan CTG yang dilaksanakan ke atas plaintif pertama, mendapati bahawa jantung janin dalam keadaan baik dan pengecutan adalah 'irregular and mild'. Pada pukul 10 pagi, defendan

pertama memutuskan bahawa plaintif pertama tidak menunjukkan tanda-tanda ingin bersalin. Walau bagaimanapun, pada 10.55 pagi, plaintif pertama pengsan akibat pendarahan teruk. Plaintif pertama dipulihkan dalam wad dan dihantar ke bilik pembedahan ('OT'). Defendan pertama, dibantu oleh defendan kedua, menjalankan pembedahan lower segment caesarean section (LSCS) ke atas plaintif pertama pada pukul 11.20 pagi. Satu histerektomi dijalankan dan plasenta percreta ditemui. Pada pukul 11.25 pagi, plaintif kedua telah dilahirkan pramasa dengan asfiksia pranatal yang agak parah dan dengan kegagalan pelbagai organ, menyebabkan plaintif kedua mengalami asfikisia kelahiran parah yang membawa kepada hypoxic ischemic encephalopathy (HIE). Plaintif-plaintif oleh itu menyaman defendan bagi kecuaian perubatan. Hakim Mahkamah Tinggi, dalam menolak tuntutan plaintif-plaintif terhadap defendan-defendan, membuat kesimpulan bahawa tiada pelanggaran kewajipan atau kecuaian oleh defendan pertama dan kedua dalam menangani keadaan plaintif pertama selepas dia pengsan. Hakim memutuskan proses kelahiran plaintif kedua dalam tempoh 30 minit dari masa plaintif pertama pengsan adalah dalam tempoh masa yang diterima di peringkat antarabangsa. Hakim juga mendapati bahawa defendan ketiga tidak bertanggungan secara vikarius kerana tiada kecuaian oleh pihak defendan pertama dan kedua. Oleh itu, rayuan ini. Isu-isu berbangkit di sini adalah, antara lain (i) sama ada Hakim Mahkamah Tinggi tersalah arah berkenaan isu tanggungan vikarius oleh pihak defendan ketiga; (ii) sama ada terdapat kelewatan oleh defendan pertama dalam menangani dan menguruskan plaintif pertama; (iii) sama ada plaintif pertama dalam keadaan hendak bersalin apabila mendaftarkan diri di hospital; (iv) sama ada plaintif pertama pengsan mungkin kerana uterusnya pecah atau perpecahan saluran darah pada uterus akibat keadaan yang dikenali sebagai plasenta percreta; dan (v) sama ada keterangan tidak dipertimbangkan secara kehakiman dengan secukupnya oleh hakim bicara.

Diputuskan (menolak rayuan)

Oleh Abdul Aziz Abdul Rahim HMR menyampaikan penghakiman mahkamah:

(1) Dalam mencapai keputusan bahawa defendan pertama dan defendan kedua tidak bertanggungjawab dan hospital juga bukan bertanggungan secara vikarius, hakim bicara telah menganalisis dengan cermat dan teliti keterangan fakta berkenaan setiap tindakan yang diambil oleh jururawat dan doktor-doktor termasuk defendan pertama dan kedua, sebagai pakar yang merawat plaintif-plaintif. Keterangan ini serta tindakan jururawat dan doktor yang berkhidmat di hospital untuk merawat plaintif-plaintif dibutirkan dalam penghujahan bertulis defendan ketiga. Hakim dengan betul memutuskan bahawa defendan ketiga tidak cuai walaupun beliau tidak mempertimbangkan tuntutan terhadap defendan ketiga secara khusus, iaitu hospital di sini, berdasarkan tanggungan secara langsung.

(2) Keterangan dan fakta kes ini tidak menyokong hujahan plaintif-plaintif bahawa defendan pertama dan kedua cuai. Apabila plaintif pertama tiba di hospital pada hari kejadian, dia tidak berada dalam keadaan hendak bersalin dan janinnya dalam keadaan baik. Fakta ini dibuktikan oleh pelbagai pemeriksaan yang dilakukan ke atasnya. Hakim dengan teliti mempertimbangkan dan memeriksa keterangan yang dirujuk oleh plaintif untuk menyokong hujahannya bahawa plaintif pertama rebah pada pukul 10.45 pagi atau lebih awal iaitu pada pukul 10.40 pagi seperti yang dicadangkan oleh plaintif, dan membuat dapatan fakta bahawa plaintif pengsan pada pukul 11 pagi. Oleh itu, jika plaintif kedua dilahirkan pada 11.25 pagi, ia adalah dalam tempoh 30 minit yang boleh diterima. Oleh itu, atas keterangan dan dapatan fakta oleh hakim bicara, defendan-defendan tidak lewat dalam merawat plaintif pertama.

(3) Plaintif pertama datang ke hospital pada pukul 6.30 pagi dalam keadaan sakit di bahagian abdomen dan mengikut laporan jururawat bertugas, dia telah membuat kesimpulan bahawa plaintif pertama tidak berada dalam keadaan hendak bersalin dan memberikan plaintif pertama Pethidine dan Phenergan untuk menyekat kesakitan otot abdomen. Defendan pertama mempertahankan keterangannya bahawa sebelum plaintif pertama pengsan dalam wad, tiada petunjuk yang mewajarkan pembedahan caesarean section dijalankan ke atas plaintif pertama. Hakim mengkaji literatur perubatan berkenaan isu persalinan pada waktu terdekat atau kehamilan jangka penuh. Setelah berbuat demikian, hakim bicara menyimpulkan bahawa plaintif tidak berada dalam keadaan hendak bersalin pada masa dia mendaftarkan diri di hospital atau pada bila-bila masa selepas itu sehingga masa plaintif pertama pengsan di wad.

(4) Dalam menganalisis keterangan yang dikemukakan oleh plaintif-plaintif untuk menunjukkan uterus pecah, hakim bicara mempertimbangkan keterangan dan pendapat defendan pertama dan defendan kedua dan juga keterangan pakar-pakar yang dipanggil oleh kedua-dua pihak. Keterangan menunjukkan bahawa uterus tidak pecah. Apabila plaintif pertama dibawa ke OT selepas dia pengsan, defendan pertama dan defendan kedua memberi keterangan bahawa uterus dalam keadaan utuh dengan plasenta. Didapati bahawa ia adalah saluran darah pada bahagian luaran uterus, di bahagian fundus, yang telah pecah (placenta percreta). Hakim bicara memerhatikan bahawa keterangan defendan pertama, defendan kedua dan pakar Dr Raman, ahli patologi Dr Patel, serta pakar dari pihak plaintif Dr Ong konsisten bahawa placenta percreta adalah satu keadaan yang luar biasa dan tidak boleh dikesan walaupun dengan teknik pengimejan yang canggih. Defendan kedua dalam keterangannya menyatakan bahawa placenta percreta di bahagian fundus dalam kes ini adalah lebih luar biasa kerana ia tidak menunjukkan apa-apa simptom. Pandangan ini dipersetujui oleh Dr Ong iaitu pakar pihak plaintif sendiri. Kejarangan keadaan placenta percreta disahkan oleh Dr Patel

A apabila dia memberi keterangan bahawa dalam 20 tahun dia berkhidmat sebagai ahli patologi dia hanya melihat satu kes sebegini iaitu kes ini. Tiada alasan untuk berlainan pendapat dengan kesimpulan yang dicapai oleh hakim bicara berkenaan pendarahan yang disebabkan oleh pecah urat.

B **(5)** Pendapat-pendapat pakar adalah persoalan fakta. Tindakan hakim bicara mengutamakan satu pendapat pakar daripada pendapat pakar yang lain tidak salah jika beliau boleh memberi penjelasan secara munasabah kenapa beliau berbuat demikian, seperti yang dibuat dalam kes ini. Mahkamah ini tidak boleh mencari salah dengan cara hakim bicara
C mempertimbangkan secara kehakiman semua keterangan dalam kes ini apabila membuat dapatan faktanya. Plaintif-plaintif gagal membuktikan, atas imbangan kebarangkalian, kes kecuaian terhadap defendan-defendan.

Case(s) referred to:

D *Batu Kemas Industri Sdn Bhd v. Kerajaan Malaysia & Anor [2015] 7 CLJ 849 CA* ***(refd)***

For the appellants - PS Ranjan (MS Dhillon, Khabir Dhillon & KB Karthi with him); M/s PS Ranjan & Co

For the 1st & 2nd respondents - Darryl Goon (Maidzuara Mohammed & Charlaine Chin with him); M/s Raja Darryl & Loh

E *For the 3rd respondent - S Anpalagar (R Anusha with him); M/s Anad & Noraini*

[Editor's note: For the High Court judgment, please see Zulhasnimar Hassan Basri & Anor v. Dr Kuppu Velumani P & Ors [2013] 10 CLJ 862 (affirmed).]

Reported by Suhainah Wahiduddin

F

JUDGMENT

Abdul Aziz Abdul Rahim JCA:

[1] On 29 July 2011, the learned High Court Judge dismissed the plaintiffs' claim against the first, second and sixth defendants with costs to
G be taxed and paid by the plaintiffs to the defendants. This is the plaintiffs' appeal against that decision. The claim against the third, fourth and fifth defendants were withdrawn during the hearing at the High Court.

[2] In this appeal, the parties shall be referred to as they were before the High Court.

H

Background Facts

[3] At all material times, the first defendant (Dr Kuppu Velumani P) and the second defendant (Dr Marlik Abu) practised at Ampang Puteri Specialist Hospital (sixth defendant) as a Consultant Obstetrician and Gynaecologist.
I The first plaintiff, Zulhasnimar binti Hassan Basri was a patient of the first defendant. The second plaintiff was born premature on 3 May 2002 at Ampang Puteri Specialist Hospital.

[4] At the early hours of 3 May 2002, the first plaintiff arrived at Ampang Puteri Specialist Hospital with abdominal pain. She was in her 36th week of pregnancy that is, the pre-term of her pregnancy. First CTG was undertaken between 6.11am and 6.29am. Vagina examination (VE) was done.

[5] At about 9am, first defendant performed VE on the first plaintiff. The first plaintiff's cervix was found thick, only 1cm. The first defendant noted the result of the first CTG, and stated that, 'foetal heart good and no contractions'. The first defendant ordered second CTG to be done and queried whether early labour since the first plaintiff felt 'mild contractions'. Second CTG was carried out between 8.50am to 9.10am. The first defendant noted second CTG result and found that, foetal heart was good, contractions were 'irregular and mild'. At 10am the first defendant concluded that the first plaintiff was not in labour.

[6] At around 10.55am, the first plaintiff collapsed as a result of severe bleeding. Code Blue was called. The first plaintiff was resuscitated in the ward and sent to the operation theatre (OT). Haemaccel was used in the ward to resuscitate the first plaintiff. PW2 (Sariman bin Saad), first plaintiff's husband was asked to sign consent papers to a caesarean section (CS) and a hysterectomy of the first plaintiff.

[7] The first defendant was assisted by the second defendant in OT. Lower segment caesarean section (LSCS) was performed on the first plaintiff at around 11.20am. A hysterectomy was conducted and placenta percreta was discovered. At around 11.25am, second plaintiff was delivered. The second plaintiff was born prematurely with severe prenatal asphyxia and with transient multi-organ failure.

[8] The second plaintiff is suffering from severe birth asphyxia leading to hypoxic ischemic encephalopathy (HIE). DW2 Dr Lim Chin Thean an expert witness and neonatologist Professor testified that 'Birth asphyxia is the most common and important cause of preventable cerebral injury in the neo natal period'. The plaintiffs then sued the defendants for medical negligence.

High Court Decision

[9] The issues raised before the High Court were as follows; (i) whether an elective CS should have been planned; (ii) whether the first plaintiff was in fact in labour upon admission or anytime; and that the first defendant had in fact provided correct assessment in treating the first plaintiff; (iii) what is the probable cause of the collapse in the first plaintiff, is it due to uterine rupture or rupture of the vessels on the uterus resulting from a condition called placenta percreta?; (iv) whether the cause of collapse is foreseeable by the first defendant; (v) whether the first plaintiff was resuscitated by the first defendant in the ward upon her collapse before sending her to the OT; (vi) whether the CS was properly undertaken by both the first and second defendants; and (vii) whether there was delay in the management of the first plaintiff by the first defendant.

A **[10]** The learned High Court Judge decided that elective CS could not be planned since the first plaintiff was in her 36th weeks of pregnancy. There is no clear indication for the first defendant to perform CS on the first plaintiff based on her medical report. A reasonable medical practitioner would not perform a CS in the absence of labour.

B **[11]** The learned judge accepted the defendants' expert witnesses and medical report/notes made by the first defendant on the first plaintiff which was supported by the expert publication on the issue of 'labour'. The High Court Judge concluded that the first plaintiff was not in labour at the time she arrived and at the time before her collapsed.

C **[12]** The learned judge found that, the plaintiffs failed to prove uterine rupture had caused the bleeding. The evidence before the court is that, the rupture of the uterine vein at the outer wall of the uterus that caused the massive bleeding. The first defendant could not have been expected to have detected the placenta percreta in the uterus or to have foreseen the events that D happened. The expert evidence of all witnesses confirmed that, it cannot be detected even through advanced imaging equipment. The detection of placenta percreta can usually happen only after delivery of the baby when the placenta cannot be delivered easily.

E **[13]** It was held that, first defendant could not foresee the cause of collapse because the presence of placenta percreta is a rare condition and could not be detected early. Moreover the first plaintiff was not in labour then. The first defendant always maintained her position that, a CS would only be performed on the first plaintiff if she was found to be in labour. The emergency CS had to be performed on the first plaintiff because she F collapsed.

[14] The learned High Court Judge accepted the defendants' case and evidence that resuscitation measures were undertaken on the first plaintiff. The first defendant admitted that it was not recorded but it was done immediately in the ward when the first plaintiff collapsed. The first G defendant's contention was supported by the fourth defendant's notes and evidence. There was an eyewitness of resuscitation taking place. Dr Marlik (the second defendant) responded to the Code Blue call, saw the intravenous line on the patient and saw fluids were pushed into the patient in the ward. Plaintiffs' expert witness (PW7) Dr Sylvian Dass opined that Dr Arul and H Dr Azhar had resuscitated the patient adequately.

[15] The learned High Court Judge concluded that, there was no breach of duty or negligence on the first and second defendants' part in handling of the first plaintiff after she collapsed.

I **[16]** The learned judge also accepted the first defendant's explanation that the time recorded might not be accurate and it was noted according to estimation at the end of the operation. The learned judge said that, doctors

normally will attend to emergencies at hand before putting the events on record. Based on the evidence of the expert witnesses, time recorded in attending the first plaintiff at the time she arrived until her collapse, was a reasonable time frame. The delivery of the second plaintiff within 30 minutes from the time of the collapse was in fact within internationally acceptable standard.

[17] On the issue of vicarious liability, the learned judge found that the third defendant was not vicariously liable since there were no negligence on the part of the first and second defendants.

Our Decision

[18] The plaintiffs raised several issues. Firstly, the learned High Court Judge delayed in delivering judgment after the case was closed. The delay had caused injustice to the plaintiffs' case. Secondly, the learned High Court Judge misdirected herself on the issue of vicarious liability on the part of the third defendant. Thirdly, there was delay on the part of the first defendant in attending to and managing the first plaintiff. The first plaintiff was in labour before she collapsed. The bleeding caused the first plaintiff to collapse. If CS was done early, first plaintiff would not have haemorrhaged and collapsed. Delay on the part of the first defendant to perform CS on the first plaintiff caused the second plaintiff to be born with severe prenatal asphyxia and with transient multi-organ failure. Fourthly, expert witnesses for the defendants were not reliable witnesses. Their evidence should not be accepted. Fifthly, documents adduced by the defendants, did not support the defendants' contentions on what transpired after the first plaintiff collapsed and was brought to OT. Sixthly, failure on the part of the learned High Court Judge to decide on quantum or make a finding of fact regarding quantum.

[19] On the issue of delay by the learned judge in delivering the judgment in this case, we do not think there is any merit in the argument. As submitted by the defendants' counsel, this is a complicated medical case which involved evidence by several experts called by the plaintiffs and the defendants. The trial itself took 52 days. The learned judge delivered a 94 page written judgment; and in it she discussed in detail the evidence and the facts material to this case in order to arrive at her decision. But more importantly the plaintiffs failed to show how the delay by the learned judge in delivering the judgment had contributed to judicial error on her part in the appreciation of the evidence and in arriving at the decision that she did.

[20] On the issue of vicarious liability of the third defendant, the hospital (the sixth defendant in the High Court), learned counsel for the plaintiffs submitted that the learned judge had misdirected herself. It was contended for the plaintiffs that the learned trial judge had misunderstood the claim against the hospital as one of vicarious liability for the negligence of the two obstetricians and gynaecologists. Learned counsel submitted that the

plaintiffs' claim against the hospital was in respect of the direct negligence of the latter in relation to the nursing staffs employed by it and for failures of the hospital organisational system. It is the plaintiffs' case that the hospital is negligent in employing inefficient and incompetent staff and had failed to engage doctors, specialists and consultants with sufficient skill to provide care and treatment to the plaintiffs. It was also contended that the hospital had failed to provide proper and effective system to deal with problems similar to that of the plaintiffs. We agree that the learned judge had not addressed the issue of direct negligence of the hospital specifically in her judgment. Instead the learned judge focussed on the negligence of the first and second defendants and found them not liable, and therefore held that the hospital was also not vicariously liable. However in arriving at her decision the learned judge had painstakingly analysed the evidence of facts as to every action taken by the nurses and the doctors including the first and second defendants, as specialists in attending to the plaintiffs. These evidence and acts of the nurses and doctors employed by the hospital to attend to the plaintiffs have been detailed in the third defendant's written submission and we need not repeat them here. From those evidence we are of the view that the learned judge had correctly concluded that the third defendant is not negligent though she did not specifically address the claim against the third defendant, the hospital, based on direct liability.

[21] The third issue raised by the plaintiffs to show that the first and second defendants were negligent, was the fact that at about 10.50am and 11am the first plaintiff suddenly collapsed. The plaintiffs put the blame on the hospital staff and the doctors, in particular the first and second defendants, for delay in performing the CS on the first plaintiff. Learned counsel submitted that the first plaintiff was in labour before she collapsed. The bleeding caused the first plaintiff to collapse. If CS was done early, the first plaintiff would not haemorrhage and the first plaintiff would not have collapsed. Delay on part of the first defendant to perform CS on the first plaintiff caused the second plaintiff to be born with severe prenatal asphyxia and with transient multi-organ failure. This is the principal issue raised by the plaintiffs to pin negligence on the defendants. However the evidence and the facts in this case do not support the plaintiffs' contention. When the first plaintiff arrived at the hospital on early morning of 3 May 2002 complaining of abdominal pain she was in her 36 weeks gestation. But she was not in labour and the foetus was well. This fact was established by the various checks performed on her (including examination of her cervix) by the staff nurse on duty. However her pulse was high at 108 and her blood pressure was 122/68. She was given Pethedine and Phernegan on instruction of the first defendant. She responded well to the medication and her pulse and blood pressure returned to within the normal range. She was then admitted to the maternity ward.

[22] Apparently it was discovered that the first plaintiff collapsed because of severe bleeding. When she collapsed her blood pressure was not recordable and Code Blue alarm for emergency was sounded. The first defendant said in evidence that the first plaintiff was resuscitated before she was moved to the OT room for an emergency CS and a subtotal hysterectomy performed by the first defendant. The first defendant was assisted by the second defendant who is also a consultant obstetrician and gynaecologist at the hospital. The second defendant had come to the first defendant assistance responding to the Code Blue alarm.

[23] The fact that the first plaintiff was resuscitated before being taken to the OT room from the maternity ward and the cause of the bleeding were heavily disputed by the plaintiffs. On the resuscitation issue the plaintiffs contended that no resuscitation was carried out at the ward when the first plaintiff collapsed. There was no record of that being done. Learned counsel for the plaintiffs submitted that the evidence as to the fact whether there was or there was no resuscitation given in the ward was conflicting and contradictory. He submitted that the first and second defendants' evidence was that there was 'insufficient resuscitation'. However DW7 evidence was that there were 'no records' of 'the timing and adequacy of resuscitation'. Learned counsel submitted that exh. D52 which was the computer print-out record which showed the various steps taken in attending to the patient the first plaintiff, had been falsified. D52 was prepared seven years after the incident. He submitted that D52 does not show 'timing and adequacy of resuscitation'. He also submitted that the drugs Phenergan and Pethidine which were administered to the first plaintiff in the ward were mentioned in the case notes but did not appear in D52. Because these discrepancies and a few other evidence, which learned counsel contended as material to the plaintiffs' case, were not considered by the learned judge, it was submitted that the learned judge had not given sufficient judicial appreciation of all the evidence in this case.

[24] However based on the plaintiffs' pleaded case, the plaintiffs never pleaded the fact of no resuscitation in the ward either in their original statement of claim or the amended version. What the plaintiffs had pleaded is that there was a failure by the defendant to take sufficient resuscitative measures.

[25] Learned counsel for the first and second defendants submitted that the evidence of no resuscitation in the ward as contended by the plaintiffs was challenged by the evidence of the first defendant who testified that resuscitation was undertaken in the ward when the first plaintiff collapsed. First defendant said she was there at the material time. Learned counsel submitted that this evidence was corroborated by exh. D52 the computer record that shows two units of Haemaccel were used in the maternity ward.

[26] Perusing the written judgment of the learned judge, we observe that the learned judge had dealt with the issue of resuscitation at great length and had considered all the evidence. Excerpts from her judgment will show this to be true:

> [109] In the light of all the above evidence I am inclined to accept the Defendant's case and her evidence that there was resuscitation in fact done. My reasons are these. First, there is record on the use of Haemaccel in the ward shown in exhibit D51. Since Haemaccel is only used for the purpose of resuscitating a patient and nothing else it goes to support her case that she used them to resuscitate the First Plaintiff. Secondly, Dr Kuppu Velumani's report at B-24 in the first paragraph states that ... "At the time the patient's blood pressure and the pulse was not recordable. Resuscitative measures were done at the same time ..." Thirdly, it is a fact that the First Plaintiff had an unrecordable BP in the ward. Upon arrival at the OT her BP was recordable and according to Dr Arul's report (at p B-80), the patient was semi-comatose, with pulse rate of 160/min and Systolic Blood Pressure was 40/mmHg. It was explained by Dr Raman that from an unrecordable state to a recordable state upon arrival at the OT, it shows that resuscitation must have taken place, otherwise her BP would not read at Systolic BP of 40/mmHg, on arrival at OT. The fact that the First Plaintiff's BP was recorded at 40m/Hg from a non-recordable state shows that resuscitation measure was undertaken.
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> [110] There is eyewitness of resuscitation taking place. When Dr Marlik responded to Code Blue call, he rushed to the ward. He saw the intravenous line on the patient. He saw fluids were pushed into the patient in the ward.
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> [111] Dr Sylvian Dass (PW7) a Consultant Anaesthesiology Intensive Care and Pain Management at PMC, Bangsar testified an expert witness brought by the Plaintiffs. PW7 is of no assistance to the Plaintiff's case on this issue. He is in fact concluded in his opinion that Dr Arul and Dr Azhar resuscitated the patient adequately. He confirmed that colloid should be used for resuscitation. He pointed out that there was no record shown by Dr Kuppu Velumani that she resuscitated the First Plaintiff. In cross-examination he was referred to Bundle G page 3 to comment on the notation in the anaesthesia record which states under the column Previous Anaesthesia as "Resuscitation->OT". His comment was that this notation in indicative of patient being resuscitated and then sent to the OT. In re-examination he further confirmed in response to the Counsel's question whether "Resuscitation->OT" is accepted term to say that resuscitation was done before going to OT.

[27] Having evaluated the evidence on the issue the learned judge concluded:

> [118] In conclusion, based on all the evidence of witnesses including the expert opinion given on this issue I have no hesitation to accept the version of the First Defendant's case that she did resuscitate the First

Plaintiff upon her collapse before sending her to the OT. The failure to record such procedure cannot nullify this fact. The result on the patient clearly supported the case of the First Defendant that she resuscitated the First Plaintiff upon her collapse. Hence there is no breach of duty or negligent on her part in the handling of the Plaintiff after the collapse.

[28] However we are of the view that the issue of resuscitation is only one of the issues raised by the plaintiffs to say that the defendants were negligence. There is a related issue, but more significant and more substantive; that is the issue of managing the first plaintiff from the time of her admission into the maternity ward until the time caesarean was performed and the second plaintiff delivered. We will deal with this issue in more detail later. For now we will examine the issue relating to the cause of the bleeding resulting in the collapse of the first plaintiff in the ward.

[29] With regard to the bleeding that caused the first plaintiff to collapse, learned counsel contended that the evidence pointed to rupture of the uterus or in medical term it is referred to as uterine rupture. What this means is that the uterus literally ruptures with the consequence that its wall (or part of it) is completely breached such that there is a passage from outside of the uterus through to the inner uterine cavity. This description was supported by the evidence of the expert Dr Raman (DW7) who gave evidence and said that for the uterus to rupture the entire wall must be breached exposing the uterine cavity to the abdomen. The learned judge accepted this expert evidence and summed up a uterine rupture as 'a sudden tear or bursting in the wall of the uterus'.

[30] Learned counsel for the plaintiffs argued that the rupture of the uterus could have been prevented because this pregnancy was not the first for the first plaintiff. This was her second pregnancy and the same doctor was attending to her. During the first pregnancy the first plaintiff also had a caesarean done on her. Therefore it was argued because of her past history, the first defendant should have anticipated the condition of the first plaintiff and should have planned for a CS if the need arises. It was submitted that the first defendant was negligent for failure to do so. It was argued that had a CS been planned it could have been done before the first plaintiff collapsed and thereby the second plaintiff could have been delivered as a normal baby.

[31] However we agree with the learned judge; the evidence says otherwise. There was no uterine rupture. When the first plaintiff was taken to the OT after the collapse, an emergency hysterectomy (removal of the uterus) was performed on her by the first defendant and assisted by the second defendant. Both of them testified that the uterus was intact with the placenta. The first defendant who was the principal doctor that performed the hysterectomy discovered that it was the vessels on the outer surface of the uterus, at the fundus, that ruptured. Her oral evidence was corroborated by her medical reports which made no mention of uterine rupture. The pathology report by

A the pathologist Dr Navinbhai Patel (DW4) also lend support to the defendants' evidence that there was no uterine rupture. Instead the pathology report made a clear and specific finding of placenta percreta.

[32] The plaintiffs' insistence that the bleeding was caused by uterine rupture was based on Dr Ong's evidence (PW3) who was the expert called
B by the plaintiffs. In his expert opinion report Dr Ong said there was uterine rupture. He formed his opinion on the interpretation of the pathology report. But the learned judge found that he never discussed with or consulted the pathologist who made the report. However after a thorough cross-examination by learned counsel for the defendants, Dr Ong somewhat
C conceded that there was bleeding from the vein which caused the first plaintiff to collapse and which necessitated emergency LSCS. Learned counsel for the defendants submitted that the earlier view of Dr Ong was because he had failed to notice that the 5 cm tear mentioned was shorter than any of the dimensions given of the uterus. He also failed to notice that the
D tear showed 'placenta tissue' and not the internal cavity of the uterus.

[33] Besides the evidence of Dr Ong, the plaintiffs also relied on evidence of other witnesses like the nurses and the medical assistants present then. However these witnesses did not have first-hand knowledge of the presence of placenta percreta at the fundus.

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[34] The learned judge has admirably analysed the evidence adduced by the plaintiffs to show a rupture of the uterus. In analysing the evidence the learned judge had gone to great lengths to explain uterine rupture and placenta percreta as understood in the obstetrics and gynaecology sense. In doing so the learned judge had considered the evidence and opinion of the
F first and second defendants as well as evidence of the experts called by both sides. Most notable about the learned judge's analysis of the issue is that Her Ladyship observed that the evidence of the first defendant, the second defendant and the expert Dr Raman, the pathologist Dr Patel (DW4) as well as the plaintiffs' own expert Dr Ong was consistent that placenta pecreta is
G a very rare condition and cannot be detected even with advance imaging techniques. Dr Marlik (the second defendant) in his evidence said that placenta percreta at the fundus as in this case is even rarer because it does not give out any symptom. This view was shared by Dr Ong, the plaintiffs' own expert. The rarity of placenta percreta condition was confirmed by the
H pathologist Dr Patel when he testified that in his 20 years of practice as pathologist he had only seen one of such a case which is the present case.

[35] Having considered the evidence on this issue, the learned judge expressed her view and conclusion as follows:

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> [140] The testimonies of all the witnesses above are in line with the cited literature and the publications on this subject. Learned Author C.H Comstock (exhibit D4) confirmed that there is no completely sensitive and specific test for the diagnosis of the placenta accrete.

[141] From the above evidence it is clear that the abnormal representation of the First Plaintiff uterus of placenta percreta is not detectable upon routine antenatal check-up. The detection of placenta percreta can usually happen only after delivery of baby when the placenta cannot be delivered easily. The expert evidence of all witnesses also confirmed that it cannot be detected even, through advanced imaging equipment. The case of the First Plaintiff is made worse because it occurred at fundus.

[142] This evidence lend support to the case of the Defendants that the intensive bleeding in the First Plaintiff which caused her to collapse was due to intensive bleeding contributed by sudden event due to the bursting of blood vessels. It is also in the testimonies of Dr Raman that placenta percreta itself does not cause pain, otherwise the First Plaintiff would have suffered pain long before. This is because the placenta takes time to grow through the uterine wall. It is a slow growing process.

[143] From all accounts, it is obvious that the First Defendant cannot be expected to detect the placenta percreta in the uterus of the Plaintiffs, or to foresee the events that happened. Thus, it is impossible to suggest that the First Defendant should proceed with CS when there is a complaint of pain due to placenta percreta. This suggestion may only hold good, upon hindsight. There is no doubt that if placenta percreta, was detected, CS could probably prevent the First Plaintiff's collapse as well as the eventual condition befallen on the Second Plaintiff.

[144] In the final analysis there was no evidence to suggest that it was uterine rupture that caused the bleeding. Evidence is clear that the rupture of the uterine vein at the outer wall of the uterus led to massive bleeding.

[36] We find no reason to differ from the conclusion reached by the learned judge on the issue that the bleeding was caused by the bursting of the vein.

[37] The next issue raised by the plaintiffs is the delay on the part of the defendants in attending to the first plaintiff. It will be recalled that in her first pregnancy the first plaintiff was also treated at the same hospital and attended by the same doctor - the first defendant. In the first pregnancy the first plaintiff also had given birth to her first born by LSCS following a failed trial labour. Though at that time she was having camphol pelvic disproportion (CPD) condition that occurs when a baby's head or body is too large to fit through the mother's pelvis, both the first plaintiff and her first born were in good condition when they were discharged from the hospital.

[38] As for her second pregnancy, the first plaintiff came back to same hospital and she was attended to by the same doctor - the first defendant. She went for her regular antenatal check-ups - four check-ups altogether - and no abnormality was detected in her condition or the foetus. Her antenatal report on her 32 weeks gestation antenatal check-up showed that her condition was normal and the ultra sound taken of the foetus showed the baby was healthy and did not give rise to any concern. According to the hospital record the 1st plaintiff arrived at the hospital at around 6.30am in the morning. She was

attended to by a staff nurse. After various checks done on her condition, the first plaintiff was admitted into the maternity ward at the hospital. She was given medicine on instruction of the first defendant.

[39] When the first plaintiff went to the hospital on 3 May 2002 in the early morning complaining of abdominal pain, she was in 36 weeks gestation in the second pregnancy. As the evidence shows, the first plaintiff collapsed in the ward at between 10.50am to 11am on the day she was admitted and Code Blue was sounded. The evidence shows that she was resuscitated in the ward (though this fact was disputed by the plaintiffs) and was taken to the OT where an emergency hysterectomy was performed on her. The complaint by the plaintiffs as to the delay is that the second plaintiff was delivered outside the internationally acceptable 30 minute window from the time the first plaintiff collapsed until the delivery of the second plaintiff. Relying on his cross-examination of DW11 (the nurse who attended to the first plaintiff) and the first defendant herself, learned counsel for the plaintiffs contended that the first plaintiff must have collapsed in the ward at about 10.45am. He also contended that the journey from the ward to the OT took about 15 minutes and that the caesarean operation only took place at about 11.25am. This he said is outside the accepted standard of 30 minutes.

[40] Learned counsel for the defendants submitted that on the oral evidence of DW11 and the first defendant as well as the contemporaneous record of time kept by the first defendant and DW11, there were two entries as to time. The first was the entry in nursing report which was 10.50am and which corresponds with the entry in the first defendant's clinical notes of 10.55am. The second entry was 10.55am in the nursing report which corresponds with 11.00am in the first defendant's clinical notes.

[41] In addressing this contentious issue as to the time entry in the records and comparing them with the oral evidence of the witnesses the learned judge wrote as follows:

> [147] The Plaintiffs also contended that there was delay in the time taken by the First Defendant to bring the Plaintiff to the OT. The telephone calls were made by the nurse twice, the first telephone call, at 10.30am and the second telephone call at 10.50am. Dr Kuppu Velumani arrived only at 11 am in the ward. Learned counsel also contended that these recorded times were wrong and illogical. He contended that in fact the Dr Kuppu Velumani should instead call on the Plaintiff at either 10.30am or 10.45am. On top of that the Plaintiffs say Dr Kuppu Velumani states in her report that she saw the Plaintiff 45 minutes after the Second CTG which would be 45 minutes after 9.10am.
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> [148] It would be useful to analyse from records and evidence in relation to time, what could be the possible time Dr Kuppu Velumani came to the ward. As I have earlier stated, from testimonies and records before me, there was nothing to disclose that the First Plaintiff was in fact in labour at any time. The decision to do an emergency CS is based on whether

the Plaintiff would eventually go into labour or not, and hence a wait see position was adopted by the Dr Kuppu Velumani. The need for CS presented itself upon the collapse of the Plaintiff in the ward.

[149] The nursing record shows that the Plaintiff collapsed at approximately 11.00am. What is more than clear based on the testimonies of the witnesses is that when the patient collapsed, Dr Kuppu Velumani was in the ward and Code Blue was sounded. From the time of her collapse to the time she arrived at the OT, in all, it took about 15 minutes. Taking into account the resuscitation done, oxygen to be given and the transfer of the First Plaintiff to OT it took 15 minutes. Going by the evidence of the expert witnesses, 15 minutes is indeed a reasonable practice of any hospital.

[150] I do not find any evidence to support the suggestion that the First Plaintiff in fact collapsed at 10.30 am instead, as contended by learned counsel for the Plaintiffs. Based on records shown I am more inclined to accept the evidence of the Defendants that she collapsed approximately around 11.00am. Thus, taking into consideration of the fact that "time" being an approximation, following the logical sequence of event, and the fact that the management of the First Plaintiff was indeed in a state of emergency, and the time of collapse was approximately at 11am, the delivery of the Second Plaintiff within 30 minutes from the time of collapse is acceptable. In fact it is an internationally accepted standard. This fact cannot therefore insinuate delay and poor management on the part of the First Defendant given the circumstances.

[42] In our view the learned judge had meticulously considered and examined the evidence relied by the plaintiffs to support the contention that the first plaintiff could have collapsed at 10.45am or even earlier at 10.40am as suggested by learned counsel for the plaintiff, and had come to a finding of fact that the collapse occurred at about 11am. Therefore if the second plaintiff was delivered at 11.25am it was within the acceptable 30 minute window. Thus, on the evidence and the finding of fact by the learned judge, it cannot be said that there was delay by the defendants in attending to the first plaintiff.

[43] Before we move on to other issues in this appeal it is necessary that we address the issue of whether the first plaintiff was in labour when she came to the hospital on that fateful morning. It is the contention of the plaintiffs that the first plaintiff was indeed in labour and therefore the first defendant should have planned for a CS having known the history of the first plaintiff's first pregnancy. Learned counsel for the plaintiff contended and argued that on the evidence, the first plaintiff on admission was at 36 weeks gestation and it was 'near term' and 'not far from term'. He submitted that there was express admission that the first plaintiff was in 'early labour'. Considering the past history of the first plaintiff's pregnancy, a caesarean section should thus be considered by the first defendant. But this was not done. So it was submitted that there was delay in the caesarean section and therefore the first defendant was negligent.

[44] However according to the first defendant, the first plaintiff came at about 6.30am with lower abdominal pain and upon report by the staff nurse in attendance she concluded that the first plaintiff was not in labour and prescribed her with Pethidine and Phenergan to suppress the pain of abdominal muscles. The first defendant maintained in her evidence that before the first plaintiff's collapse in the ward, there was no indication that warranted a CS to be performed on the first plaintiff. However learned counsel for the plaintiffs argued that on the opinion of the expert Dr Ong (PW2) (who testified for the plaintiffs) considering the first plaintiff's first pregnancy was with a history of CPD an elective CS should be prepared for her second pregnancy. But Dr Ong also said that if a CS be planned it should take place at 38 weeks gestation.

[45] The learned judge approached the issue whether a planned CS should have been considered or otherwise by examining the fact whether on admission or at any time after that the first plaintiff was in labour. The plaintiffs' case is that she was. But the first defendant said she was not.

[46] The learned judge devoted more than 30 paragraphs in her judgment discussing the evidence by both sides on the issue. She had also considered the expert evidence of Dr Ong and Dr Raman together with the evidence of the first defendant. In addition, the learned judge had also reviewed the medical literature referred or cited to her on the issue of labour at near term or on full term pregnancy. Having done so she concluded that the first plaintiff was not in labour at the time of admission around 6.30am on that fateful morning or any time after that up to the time when the first plaintiff collapsed in the ward. In arriving at this conclusion the learned judge had preferred Dr Raman's expert opinion over that of Dr Ong. The learned judge wrote in her judgment as follows:

> [79] Upon my careful scrutiny of Dr Ong's evidence, what he said was this. First, he suggested that labour can be diagnosed solely on the basis of uterine contractions in his testimonies recorded at page 145 of the notes of evidence. In answer to a cross-examination put to him, he said there must be regular uterine contractions. He took the view that the First Plaintiff was in labour because "… there was definite presence of regular uterine contractions" in the second CTG tracings. When in fact, the second CTG tracings of Fist Plaintiff, show irregular contractions of the uterus, and good foetal heart rate. At the end of it all I find Dr Ong's evidence rather confusing when he concluded that the second CTG shows the First Plaintiff was in labour. In my view, when he concluded that the First Plaintiff was in labour relying on the second CTG, where there were mild regular contractions Dr Ong was prevaricating the issue of labour. It is a fact that there were no regular contractions in the second CTG tracings as we can see from the charting.
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> [80] Having examined the cited publications above, I am inclined to accept the evidence of Dr Raman as well as the testimonies of Dr Kuppu Velumani that the First Plaintiff was not at any time in labour. In my view the testimonies of Dr Raman are well supported by the literature on the

definition of "labour". In both exhibits D16 and D12 the learned authors make it clear that an onset of labour must always be presented with uterine contractions plus dilation of cervix. In fact in D15, learned Author Derreck LLewelly-Jones in "Obstetrics & Gynaecologists" observed that onset of labour is difficult to determine with accuracy and at most it can be said as, the time after which uterine contractions cause the progressive dilation of the cervix beyond 2 cm with painful contractions usually occurring at least every 10 minutes.

[81] It appears that both parties sometimes do rely on the same literature and publications. However learned counsel for the Plaintiffs had not referred to them in their right context. There was nothing in all these publications that have placed reliance on contractions alone without dilation of cervix to indicate labour. All the literatures cited in fact, accepted the position that the contractions must be regular and progressive to establish that a patient is in labour. None of which was present in the First Plaintiff at any given time.

[82] It is noted that in the course of trial the witnesses had been referring to the terms "early labour, established labour, active labour, and established pre-term labour". Dr Ong agreed that the First Plaintiff was in early labour based on second CTG tracings but yet agreed that she may not progress to labour at the end. He in fact uses "probably early labour" at page 66 of his written opinion. Finally, Dr Ong makes a distinction between early labour and established labour.

[83] Dr Raman explained "active phase of labour" to mean a phase where cervix dilates to more than 3 to 4 cm with contractions. He explains "latent phase" of labour is where the cervix dilates less than 3 to 4 cm with contractions. He further explained that "latent phase" does not progress to "active phase". To be in labour, a person has to be in the "active phase."

[84] Perusing through all the publications cited on this issue plus the evidence of both medical witnesses and expert opinion by Dr Raman, I agree with the Defendant that, on the facts of the present case there is no presence of labour in the First Plaintiff. This is because there was no regular uterine contractions and dilation of her cervix, for any conclusive evidence that she was in labour.

[85] The Plaintiffs further mounted criticism on the lack in labour charting or partogram by Dr Kuppu Velumani. Such failure was taken to suggest to have caused her failure to detect that the First Plaintiff was in labour. Dr Ong commented in his report that this failure was not an appropriate management of the patient by Dr Kuppu Velumani. In fact according to him in a patient with previous CS her blood pressure and pulse should be monitored half hourly or hourly. Since there was no BP/pulse chart of the First Plaintiff during this period in time, he could not appreciate what was her BP and pulse rate while she was in the ward on 3.5.2002.

[86] Dr Raman in his evidence explained that labour charting is only necessary to be commenced when a patient is in labour. He was referred to exhibit D45, which supported his view that a partograph chart must only be started when a women is in established labour also known as the

A active phase of labour. According to him, this is a standard practice. Exhibit D45 is a publication by the Royal College of Obstetricians and Gynaecologists entitled "Life Saving Skills Manual". Appendix 2 of the publication, explains on how to use partograph.

[87] In any event from the first CTG to the second CTG there was no
B indication that the First Plaintiff was in labour. Following the expert opinion of Dr Raman and the literature in exhibit D45, there is no valid criticism against Dr Kuppu Velumani for not starting partograph charting. Thus the criticism by Dr Ong that there was no labour charting will only hold good if the First Plaintiff was in labour.

C **[47]** Having scrutinised the evidence and the reasoning by the learned judge we are of the view that her conclusion on the issue does not warrant our intervention. The opinions of the experts are a question of fact. We see nothing wrong in the learned judge's preference of one expert opinion over the other if she can reasonably explain the preference (which in this instant we think the learned judge had done). In *Batu Kemas Industri Sdn Bhd v.*
D *Kerajaan Malaysia & Anor* [2015] 7 CLJ 849; [2015] MLJU 257, this court speaking through the judgment of Mohd Zawawi Salleh JCA said:

[40] In our view, when expert opinions are in conflict with one another the court is obliged to assess the evidence and accept if necessary the most reliable parts in forming its decision (see *Mohamed Ismail Mohamed*
E *Shariff v. Zain Azahari Zainal Abidin & Ors* [2013] 2 CLJ 717; [2013] 2 MLJ 605). In that process the court may put relevant questions to the expert for the purposes of clarification or eliciting further information (see *Lim Teck Kong v. Dr Abdul Hamid Abdul Rashid & Anor* [2006] 1 CLJ 391; [2006] 3 MLJ 213).

F **[48]** The next issue raised by the plaintiff's counsel is that there is insufficient judicial appreciation of the evidence by the learned trial judge, particularly of the arguments raised by counsel for the first and second plaintiffs. For example, learned counsel for the plaintiffs contended that the learned judge had misunderstood the 30 minute period or window. He
G submitted that there was no dispute that the delivery of the baby by caesarean section was undertaken only at 11.25am, the operation having commenced at 11.20am. However he insisted that the delivery must be performed within 30 minutes from the time of collapse of the mother, the earlier the better. In this regard learned counsel for the plaintiffs argued that the first plaintiff
H had collapsed in the ward at 10.45am not at 11am as found by the learned judge. He submitted that on the evidence, the first defendant said repeatedly that she saw the first plaintiff at 10.45am and at that time the first plaintiff was already in a state of collapse. However learned counsel's contention is at variance with the contemporaneous documentary evidence. The nursing report and the first defendant's clinical notes recorded that at around 10.55
I to 11.00am in the ward, the first plaintiff's BP could not be recorded and her pulse was found to be 'feeble'. Code Blue was sounded.

[49] In our view the learned counsel's criticism of the learned judge for insufficient judicial appreciation of the evidence is misplaced. On the contrary reading through Her Ladyship's judgment we are of the view that she had painstakingly considered all the evidence by the plaintiffs in trying to prove their case against the defendants. As an example we reproduce below one the paragraphs in the judgment where Her Ladyship addressed the plaintiffs' argument on the delay in the management of the first plaintiff by the first defendant:

> [93] The Plaintiff mounted a case of delay in the management of the First Plaintiff by Dr Kuppu Velumani. It is the Plaintiff's case that CS should have been done on the First Plaintiff at 10.00 am. The Plaintiffs relied on the evidence of Dr Marlik and argued that 15 minutes time taken, to bring patient from the ward to the OT is a delay. The Plaintiffs contended that Dr Kuppu Velumani gave various inconsistent records of time on the events. The Plaintiffs argued that if time is approximation it should be so stated in the report or notes. The Plaintiffs contended she should have attended and came up to the see the First Plaintiff right at 10.30 am when she received the first phone call from the nurse.

[50] Thereafter the learned judge went on to discuss the evidence in detail. But more importantly she had relied on the oral testimony of the witnesses corroborated by contemporaneous document evidence to arrive at her conclusion.

[51] The learned judge had also addressed the concern by learned counsel for the plaintiffs regarding the expert witness Dr Raman whose evidence, the learned counsel urged the court to treat with circumspect and not to attach too much weight to it. One of the complaints by learned counsel for the plaintiffs against Dr Raman's testimony is that Dr Raman and the first defendant had known each other long before the case. In fact they were colleagues at the University Hospital before this and together they have co-authored some publications. We are of the opinion that the learned judge was correct to dismiss this complaint when she wrote:

> [160] In the circumstances of the present case I am not able to appreciate the objection raised by the Plaintiffs. There is no reason to disqualify an expert witness here merely on the basis that they were one time colleagues. Being in the same area of specialisation, it is not uncommon for the doctors or any member of other profession to remain friends with one another. There is no law to suggest that just because the witness is a colleague his opinion is bias.
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> [161] In accepting or rejecting evidence particularly an opinion of an expert the predominant factor that merits consideration should be based on its scientific value upon critical scrutiny against the whole of other evidence. I have earlier alluded to this point in the earlier paragraphs in deciding to accept the evidence of Dr Raman.

A [162] Another issue brought by the Plaintiffs' counsel in relation to the testimonies of expert is on the mode of evidence recording. Learned counsel drew the attention of the court that when Dr Ong testified as PW3 his evidence was recorded by the Judge manually. Later at the time when Dr Raman testified as DW7 the court was equipped with electronic recording system, the court recording transcription
B (CRT). Under this system statement made by the witnesses is recorded on real time as he speaks, and the statement would appear on the screen. There is one screen in front of the witness himself, one each in front of counsel for the Plaintiffs and Defendants and another before the Judge. Simultaneously all parties, the witnesses, counsel and the Judge are able to see the recorded statement on
C the respective screens. Sometimes, particularly so on technical medical evidence if the witness who testified finds the testimonies to inaccurately recorded corrections can be made on the spot. Encik PS Rajan took up issues that the recording done in this way would give advantage to Dr Raman as opposed to the manually recorded
D testimonies of Dr Ong because he was able to make correction on the screen. This also according to Encik PS Rajan would give opportunity for witness to think of what is the correct answer to give. He urged this court to give due regards and weight to evidence of these two experts taken into account these two modes of recording.

E **[52]** The burden to prove negligence of the defendants is on the plaintiffs. In this appeal, there is no issue canvassed before us with regard to the test to be applied in determining the standard of care to be observed by the defendants. There is also no serious issue as to the question whether or not there is a duty of care owing by the defendants to the first plaintiff.
F Nevertheless these issues were all addressed by the learned judge in her judgment. It appears to us that these issues are non-issues as between the plaintiffs and the defendants. The issues that were argued and canvassed before us in this appeal centred primarily on issues of fact and evidence and how the learned judge had handled them. In this regard we cannot find fault
G with the manner the learned judge had judicially considered all the evidence in this case in arriving at her finding of facts.

[53] On the aforesaid consideration we are unanimous that this appeal be dismissed since we agree with the learned judge that the plaintiffs had failed to establish, on a balance of probabilities, a case in negligence against the
H defendants. We awarded no costs in this appeal and ordered that the deposit be refunded.

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